**Fixing Healthcare Episode 13 Transcript:**
**The Bonus Episode**

**Jeremy:** Hello and welcome to the Fixing Healthcare podcast. I am one of your hosts, Jeremy Corr. I'm also the host of the popular New Books in Medicine podcast. With me is Dr. Robert Pearl. For 18 years, Robert was CEO of The Permanente Medical Group, the nation's largest physician group. He is currently a Forbes contributor, a professor at both the Stanford University School of Medicine and Business, and author of the bestselling book "Mistreated: Why We Think We're Getting Good Health Care – and Why We're Usually Wrong."

**Robert**: Hello everyone and welcome to our podcast, aimed at addressing the failures of the American healthcare and finding solutions to make it once again the best in the world. In today's episode, Jeremy and I will dissect and discuss the best and boldest ideas from the first two seasons of the show. All six guests from Season One were chosen for their expertise within the current healthcare system, while in Season Two, which concluded last month, we interviewed six guests from outside the medical mainstream.

**Jeremy**: Today's podcast is a bonus episode, which will examine the best ideas from seasons one and two while looking ahead to our upcoming third season. Robert will weigh in from the perspective of the physician and national healthcare leader. I will provide the patient's point of view.

**Robert:** As part of this episode, we'll ask you, the listening audience, to vote on what you believe were the most valuable ideas from the second season and give us your own thoughts on how to improve American healthcare in the future. You'll be able to vote by going to my website RobertPearlMD.com and clicking on the new "Survey To Fix American Healthcare."

**Jeremy**: In Season One, our guests delivered visionary plans for the future, drawing from more than 10,000 listeners and sparking a national debate. The best and boldest ideas were part of the first ever "Fixing Healthcare Survey." You -- the listeners -- voted for your 10 favorite solutions, and we begin this episode by announcing the winning ideas and discussing each of them.

Let's get started with two ideas from Don Berwick. Don is the founder of the Institute for Healthcare Improvement or IHI and a former CMS administrator. During our interview, he advocated for healthcare's now-famous Triple Aim and called for a reduction in performance metrics for physicians. Let's play the clips.

**Don Berwick:** We need a system of three goals of better care for people when they're in the care system, better health for populations, and lower per capita cost through improvement, not through rationing or withholding. That was the mission I brought to the Centers for Medicare & Medicaid Services when I took over in the Obama administration. The Triple Aim became tattooed on every single person there: better care, better health, and lower costs.

**Jeremy:** And here's Don talking about putting our nation on a, quote, measurement diet:

**Don Berwick:** We have made so many stupid rules and those stupid rules have to be stopped. They have to be taken down. Many of the rules are about metrics which make no sense, metrics that don't help people at all. We need to put ourselves on a metric diet, a measurement diet. I've called for a reduction in the amount of

measurement that's going on in American healthcare by 75% over a four or five year period.

**Jeremy:** Robbie, in the "Fixing Healthcare Survey," listeners rated these ideas number 10 and eight, respectively. Please, tell us your thoughts.

**Robert**: The triple aim addresses what some have seen as an intrinsic conflict for physicians between caring for individuals and entire populations of people. Don has emphasized that doctors need to do both. And that as part of the process, physicians need to lower the total cost of medical care. Don was prescient when he and the Institute for Healthcare Improvement proposed the Triple Aim framework. In the short-run doctors can focus on one of the three and contribute to healthcare improvement, but if the other two legs falter, all patients will suffer as a consequence. The health of everyone is dependent on the environments in which they live and if healthcare becomes increasingly unaffordable, everyone suffers.

The triple aim reminds me of a sign I saw at a department of health office in Oregon. At the top it said in big, bold letters, "Quality, Service, Cost," and at the bottom in small letters, "Pick Any Two." We can do much better with the advances in the science of medical practice. And we must. As an example, it's less expensive to prevent a heart attack, stroke or cancer than treat it. And we have massive opportunities to raise quality and lower costs by addressing societal issues like smoking, obesity and the avoidable medical error.

This leads to the question of metrics. As Don and I both know, doctors, particularly in primary care, are frustrated by the large number of metrics against which they are being measured and how these performance numbers are used. To address those concerns, I started a series of articles last month on burnout. The first focused on primary care and the topic of comparative performance reporting. In the article, I pointed out that the challenge of going on a "measurement diet" is that these measurements are proven to save lives. They're not just arbitrary "metrics."

As an example, success in treating hypertension is an important measurement. When doctors help patients control or reverse high blood pressure, 40% of strokes can be avoided. Combining blood pressure control with lowering blood lipids, that contributes even further. When doctors help patients normalize both of these measures, 50% of heart attacks can be prevented. What about screening people over the age of 50 for colon cancer? If every doctor and medical group in the country could match the performance of the best, we would save tens of thousands of lives every year. All it takes is for most patients, at-home, to do a stool test that takes five minutes once a year, not an invasive colonoscopy that requires a bowel prep and risks intestinal perforation.

The biggest problem is not the metrics themselves, but how they are used. What's needed is to shift our measurement mindset in this country. Monthly "report cards" that focus on those who are failing are not the best way to inspire doctors to change their behaviors. Instead, leaders can use this data to help all doctors improve and then celebrate the collective success. I refer to this approach as "group excellence." Done well, it would dramatically improve the health of the whole nation.

**Jeremy:** In our final episode of season one, healthcare futurist Ian Morrison recommended that we put more physicians in leadership roles. Listeners ranked this idea number nine.

**Ian Morrison:** I think on the issue of provider satisfaction there's no doubt … that the majority of doctors feel burned out, feel in some senses, alienated and that their work is not valued … and I do think that providing systems with control, where the physicians, as you said in your book, lead the organization. I'm not 100% convinced you have to be a doctor but I think it sure helps if you're a clinician leading large organizations. I think trying to encourage colleagues to transform in the name of improving care for patients is a professional motivation and these organizations need to be professionally led with that kind of ethos.

**Jeremy:** Robbie, in your book "Mistreated," you wrote extensively about physician leadership. In fact, you called it one of the 4 pillars of healthcare transformation. What are the benefits of this idea and what are the barriers?

**Robert**: I concur with Ian that it would be beneficial to have more physicians in leadership roles rather than just hospital administrators or insurance company executives. What we know is that practicing physicians are reluctant to follow leaders who aren't clinicians. They worry that these administrators will focus more on the bottom line than maximizing quality outcomes. But physicians will be willing to make clinical practice improvements when the ideas come from colleagues they know and respect.

Organizational change is difficult to accomplish even under the best of circumstances. Encouraging doctors to innovate and embrace new approaches is particularly challenging due to the risks any new practice has of harming a patient. A great example of what's possible comes from my experience as CEO in Kaiser Permanente. Traditionally, total joint replacement required three days in the hospital following surgery. But through the efforts of a variety of physician leaders, 60% of the surgeries were done as an outpatient by the time I left. That means that these patients avoided the risks of developing a hospital acquired infection or experiencing a medical error.

The problem is that most doctors haven't had the training and education needed to be effective leaders. A few years ago, I wrote an article for the New England Journal of Medicine with a controversial proposal. I recommended that medical students spend an entire month of their final year in a business school, learning about teamwork, motivation and operational excellence.

And I think that organizations need to think about leadership development, similar to how they think about capital spending for new buildings and machines. The return on investment doesn't happen within 12 months. It occurs over the following decade. As the challenges facing the healthcare system increase, I'm confident that added investments in physician leadership will prove both necessary and prudent.

**Jeremy:** Moving on to the ideas that our voters ranked number seven and number six. Both have to do with the role of technology in healthcare. Dr. Eric Topol, the health-tech expert and bestselling author, and Zubin Damania, known to his army of followers as ZDoggMD, weighed in on healthcare's outdated technologies. Dr. Z wants to give patients more digital choices and greater convenience. He says:

**Zubin Damania:** Go where the patients need us: telehealth, visit, phone, email, Skype. All those things are where our patients want us, but instead we're stuck behind a clunky EHR that looks like it was built in the '90s, or worse. It looks like it has a DOS prompt. Go where they need us.

**Jeremy:** And Eric, who's considered one of the nation's foremost experts on artificial intelligence in healthcare, talked about how technology can reduce hospitalizations and costs.

**Eric Topol:** Now, how can we reduce hospital costs, because that's $1.2 trillion a year and rising quickly? The way we can do that is get rid of hospital rooms … and these people should be at home to avoid the one in four chance of a serious harm or error that takes place in the hospital … We have exquisite remote monitoring capabilities now and we should be using that, we should be developing that.

**Jeremy:** Robbie, these were very popular ideas, according to our listeners. So, what's wrong with the healthcare technologies we have today?

**Robert**: As you know, I teach a strategy class at the Stanford Graduate School of Business, and in the first session, I ask the students, "What is the number one-way doctors exchange vital patient information?" Students might assume it's via email or through smartphones. When I tell them the correct answer is the "fax machine," do know what they say? "What's a fax machine?" Healthcare technology remains left over from the last century. We need to bring IT into the 21st century.

Like Dr. Z, I believe we need to offer patients the same convenience in their healthcare that they demand from every other industry, including finance, travel and retail sections. Patients should be able to make appointments online, review their medical information 24/7, and communicate with their physicians through secure e-mail and video rather than having to miss work or school to drive to the doctor's office. In addition, making electronic health record systems easy to use for both physicians and patients will be essential. To do so will require those who sell them to open the Application Processing Interfaces, or APIs as they're called, and allow third party developers to create user-friendly applications, just as Apple as done for the iPhone.

Like Eric, I'm optimistic that technology, particularly Artificial Intelligence, can elevate the excellence of medical care we provide to our patients. But as I look to the future, we need to discern what's real and what's hype. When it comes to AI in healthcare, there are two relevant categories. The first is visual imaging diagnosis in the specialties of radiology, pathology, dermatology and ophthalmology. Here, machines are already making more accurate diagnoses than physicians. Unlike doctors who must depend on "heuristics" – simple rules to diagnosis cancer in a pathology specimen or from a mammogram – artificial intelligence uses a much more sophisticated approach. The computer application is given 10,000 specimens, half of which have been proven to be cancerous and half not. Using deep learning, it contrasts the two sets and identifies hundreds of subtle differences that when added together are more accurate than what the human brain can accomplish.

At the same time, I differ in one way from Eric. He felt on the podcast that AI would not replace physicians in making these diagnoses, but instead it would augment physicians. I would say that AI won't replace all doctors, but when AI can read literally hundreds of slides in a few minutes at a cost of less than a dollar each, that's a recipe for disruption and, as a result, relative to these visual specialties, we'll need far fewer physicians.

In contrast to these types of applications, some companies are promoting the idea that AI will be able to replace doctors in making general, office-type diagnoses. Here, I predict AI will fail, not because of the technology, but because

the data in the electronic health record is poor, inexact and often wrong. Ultimately, artificial intelligence tools can't be any more intelligent than the information it has been given.

**Jeremy:** Robbie, let's discuss two other ideas that listeners liked from Eric Topol and ZDoggMD, both on the topic of healthcare reimbursement. Here's Dr. Topol's idea, which voters ranked number five overall:

**Eric Topol:** In the United States, relative to other countries, there's incentives to do things that are unnecessary. Whether that's done at a conscious level or, more likely, it's done at a subconscious level … We're set up to fail. Ideally, a different way to handle this would be all physicians would get a salary, you know, a reasonable compensation and there would be no incentives for this type of effort that's unnecessary.

And the other, voted number two by listeners came from ZDoggMD. Here's his recommendation that we pay physicians on a prepaid, capitated basis, focusing on the quality of medical outcomes achieved, rather than the quantity of care provided.

**Zubin Damania:** Think of it this way, it's like a prepaid Netflix plan. You pay twenty bucks a month for Netflix and you get to watch the videos that you want. In healthcare, it means that you pay the clinicians, or the health system, a flat amount of money, and their goal is to keep you healthy for that amount. Now, I think that in itself may not be enough. I think what you need is some incentive to continue to work really hard and improve your efficiency and care, so that you can share some of the savings that are generated when you actually do the right thing for patients. It should be that by doing good in the world for patients, we do well financially. I think capitation and its variants are the closest to that, especially for primary care.

**Jeremy:** Robbie, what do you think?

**Robert**: There's broad agreement among policy experts that moving from fee-for-service to pay-for-value is essential. A fee-for-service approach reimburses doctors for the volume of procedures they do, even when these interventions don't add any value and lead to avoidable complications. In contrast, pay for value rewards superior outcomes, encourages preventive services and penalizes medical errors.

But despite broad agreement that pay-for-value is superior to fee-for-service, the pace of change remains incredibly slow. That's because just about everyone—including hospitals, insurance companies and doctors—all benefit from the current payment system. The only people being harmed and mistreated are the patients and their employers. When doctors, hospitals and drug companies in a fee-for-service world can raise prices almost at will and simultaneously drive higher utilization, they've got a guaranteed winning financial proposition. In contrast, to succeed in a pay-for-value system, these same players would need to become more efficient and effective, and that would require significantly more work and effort.

Change won't come through these legacy players. Fee-for-service is like an addictive drug. Drive up utilization by 10% and you are rewarded with more income. But after a while, the high wears off and you begin to drive up utilization by another 10% and then after that another 10%.

Listeners should ask themselves if they would ever hire a contractor to remodel their kitchen or bathroom and agree to pay on a time-and-material basis for whatever the person did. The answer is no. Then why do they think it would work when it comes to their healthcare?

Through a capitated approach, doctors and hospitals are paid a set fee to provide care to a population of individuals. Therefore, they're rewarded for doing the right thing for patients the first time. Until we move from fee-for-service to capitation, we will see both the cost of care and the prices charged rise while quality lags far behind.

**Jeremy:** So true, Robbie. Next up, the number four idea came from Dr. Halee Fischer-Wright, the current CEO of MGMA:

**H. Fischer-Wright:** There's so many solvable problems we keep talking about in practice, to your point, for the last 40 years. And yet we keep making many of them worse. Two of the biggest are administrative complexity and regulatory burden. Solve them and you rapidly save hundreds of billions of dollars, reduce burnout, improve frontline satisfaction, and free up amazing time and resources that actually could be used to improve life expectancy and improve the actual health of people leading to quality outcomes.

**Jeremy:** So, Robbie, do you believe we could save hundreds of billions of dollars each year by reducing administrative complexity, as Halee suggests?

**Robert**: Jeremy, I think it depends on how it is done. Ask yourself, "Why do insurance companies make the billing and claims process so difficult?" They do it because they're afraid of what will happen if they don't. Think of all this paperwork like speed bumps on a busy road, they're there to slow things down on purpose. In our current fee-for-service system, doctors are rewarded for providing more tests, more procedures, more hospital days. If there were no speedbumps, insurers worry that doctors and hospitals would do more and more and more. And as studies show, most of the time, more care does not equate with better care.

Even in the current model, with doctors having to obtain prior authorization for expensive tests and procedures, the Mayo Clinic has demonstrated that 30% of what physicians recommend today adds no value. And yet doctors go ahead anyway. And often, when there is a preventable complication, physicians and hospitals can bill the insurer twice: once for the procedure that produced the complication and another to address the medical error.

Were our nation to move to a capitated model, these restrictions would no longer be necessary. More importantly, people's health outcomes would improve, since physicians would now have a financial incentive and added motivation to focus on prevention, avoid complications and eliminate medical errors.

**Jeremy:** The third-most popular idea on the "Fixing Healthcare Survey" once again came from ZDoggMD. In episode one, he told us that American healthcare desperately needs more primary care physicians.

**Zubin Damania:** So, the first thing we're going to do is we're going to invert our healthcare from a sick-care, reactive system that puts band aids on problems and sends them back into the street to a focus on actual healthcare: prevention, education, et cetera, that actually keeps people out of trouble. And in order to do that, the first thing you have to do is start inverting the problem we have in this country, which is too

many specialists, and hospitals, and not enough primary-care, prevention: OB/GYN, geriatrics, pediatrics, family medicine, internal medicine, et cetera.

**Jeremy:** Robbie, how do we start “inverting the problem” as Zubin put it?

**Robert**: I concur with ZDoggMD that our nation has too few primary care physicians. Studies have demonstrated that primary care has a 5 times greater impact on life expectancy and overall health than specialist care. And yet, just 4% of all healthcare spending is on primary care. Imagine what could happen if we increased those dollars, let’s say, to 6% and reduced the number of patients each physician had to see each day by a third. Imagine how many heart attacks, strokes and complications from diabetes could be avoided if doctors had more time with each patient. With higher salaries and more support, primary care would attract more medical students and keep more of today’s physicians from burning out or retiring early.

By investing in primary care and avoiding medical problems in the first place, our nation would need fewer specialists and fewer hospitals than we have today, more than offsetting the added primary care dollars spent.

Jeremy, I worry, that as logical as this approach is, our country won’t go for it. In the U.S., primary care is not given the respect it is due. As a society, we perceive the maximum value of healthcare to come from the specialist who unblocks the coronary arteries of a heart attack victim or the surgeon who does a complex cancer resection. We ascribe far less value to the primary care doctors who prevent these medical problems from happening in the first place. To solve the primary care shortage and invert the problem, we will need both systemic improvements and changes in the culture of medicine.

**Jeremy:** Closing out season one, the number one idea as voted on by listeners came once again from Eric Topol. Robbie, as you remember, this one surprised both of us. Let’s take a listen.

**Eric Topol:** The United States is the only country that does not provide healthcare to all of its citizens. And that needs to be fixed. We can’t address the reduction in these critical metrics unless we provide healthcare equitably among all U.S. citizens. So, that’s step number one.

**Jeremy:** Robbie, you may call that we wrote an article in Becker’s Hospital Review about this idea. Given Eric’s encyclopedic knowledge of technology in healthcare, we predicted he would zero in on technology or possibly genomic medicine. Instead, he opened with a call for universal healthcare coverage. Why do you think he proposed this concept first and why do you think it was voted number one by our listeners?

**Robert**: Eric and the listeners both recognize that unless healthcare is affordable and accessible, the health of individuals and communities will suffer. Eric understands that without universal coverage, people can’t pay for or access medical care. His call for universal coverage resonated so strongly with listeners because people can no longer afford their out of pocket expenses. A recent survey showed that 50% of American households would have to borrow money if a family member became severely ill. We know that, at present, a quarter of parents scrimp on insulin doses. This is a life-saving medication for children with Type I diabetes. And they do so because insulin has become so expensive that they can’t afford to buy the full dose prescribed.

Eric's recommendation was voted number one because the biggest challenge we face as a nation is the rising cost of healthcare. And here's the kicker: It doesn't matter if the costs are covered by the government or private insurance or patients themselves. If costs continue to rise at their current rate, nobody will be able to afford American healthcare in the future. This is one of the reasons I wrote the book "Mistreated: Why We Think We're Getting Good Healthcare—and Why We're Usually Wrong."

Looking at the top ten ideas voted for by listeners from season one, I am a strong proponent of all of them. In my mind, I often combine them as "The Four Pillars of healthcare transformation." Care that is integrated within and across specialties, paid for on a capitated not fee-for-service basis, technologically enabled and, finally, clinician led.

**Robert:** Now, Jeremy, let me shift the focus to you and ask the following question. Thinking back on the entire first season, which ideas resonated most powerfully with you as a patient?

**Jeremy:** Robbie, I think the idea that resonated with me most came from many of our guest in different ways. ZDogg, Dr. Fischer-Wright and Dr. Feinberg all discussed focusing more on primary care as a preventative concept. Halee and ZDogg both discussed patients having skin in the game with empowered partnerships where doing basic things like eating right and exercising with the help of primary care would keep them from spending more downstream. I also really like how physician burnout was addressed. As a patient, when I am talking to my doctor, I want them to be engaged with me and listening to me. Dr. Zeev Neuwirth said it best. You do not want a doctor who is burned out standing over you in the operating room. Dr. Topol said that burned out physicians are twice as likely to have medical errors. I also really like increased use of technology such as telemedicine and wearables to drive down the cost of care. And I know this concept came from season two, but Elizabeth Rosenthal's patient advocacy really resonated with me. I believe that episode is must listen for every healthcare consumer in America. She does a fantastic job of addressing how patients can find the best price and how to fight unreasonable medical bills.

**Robert:** Jeremy, what do you believe is the role and responsibility of the patient in solving the current healthcare crisis?

**Jeremy:** First and foremost, I believe, the American public needs to be healthier as a way to drive their own personal healthcare costs down. Eating right and exercising go a long way to preventing chronic conditions and the medical costs that come with them down the road. I believe it is also the patient's responsibility to demand the same kind of conveniences in healthcare that they do from other industries such as shopping or banking. Patients need to shop around to ensure they are getting the best price possible. Also, if they get a bill in the mail they don't understand or if there are outrages charges, call in, ask questions, and make sure they understand what they're paying for. Patients need to stop accepting the bad current state of American healthcare.

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**Jeremy:** What an incredible first season that was. And if you, the listeners, want to see how the voting played out for the first-ever "Fixing Healthcare Survey," you can check out the top 10 ideas at www.RobertPearlMD.com.

Now let's turn our attention to season two. We realized after season one that even the best ideas would make no difference unless they could be implemented. And given how little progress our nation has made toward improving health or extending life-expectancy over the past decade, we decided to invite guests from outside the healthcare mainstream to share their thoughts on fixing healthcare. Here are a few of the highlights.

**Jeremy:** From India's top cardiac surgeon, Devi Shetty …

**Devi Shetty:** If the solution is not affordable, it is not a solution. There is no point in me talking about all the advances in heart care or in cancer care if 90% of the world's population cannot afford it. I did my first heart surgery in Kolkata and the patient paid $2,000 for the heart surgery. Thirty years later, we're doing the same heart surgery for less than $1,200. Robbie, tell me what was costing $2,000 in healthcare? Thirty years later, it is costing $1,200.

**Jeremy:** From business consultant and Stanford professor Chip Heath …

**Chip Heath:** When we approach a change situation, things may look grim, but even in the grimmest situations, there are bright spots. There are some people that are already making progress on making the change.

**Jeremy:** From patient advocate and Kaiser Health News editor, Dr. Elisabeth Rosenthal …

**Elisabeth Rosenthal:** This sounds like terrible advice to give someone who's about to have a baby, but I think my advice is be careful. When someone says, "Do you want the nice nitrous oxide? Do you want the birthing tub? Do you want a private room?" You have to say, "Okay, well how much is that going to cost?" Because the last thing you want as a new parent is to end up with a $10,000 bill you didn't anticipate.

**Jeremy:** From healthcare leader and recent author, Dr. Zeev Neuwirth …

**Zeev Neuwirth:** The essence of marketing is all about understanding people, understanding their needs, finding customer segments, customizing solutions for those segments, delivering those solutions, and making sure that you're engaging your customers and continue to make your solution relevant to them. And if you think about it, that actually isn't all that different from the fundamental principles of medical care.

**Jeremy:** From the medical historian with an Oxford PhD, Dr. Lindsey Fitzharris …

**Lindsey Fitzharris:** I think that the people who are quote, the pioneers, they think fundamentally differently. Maybe they're a good combination of both analytical and creative and again, they can think outside the box.

**Jeremy:** And, finally, social media's leading physician voice, Dr. Kevin Pho …

**Kevin Pho:** Clinicians need to use social media to make our voices heard. Our healthcare world is changing by the day. There's going to be some seismic changes in the coming years. And I think it's important for practicing clinicians to share their story and have a voice in that conversation.

**Jeremy:** Now that you've heard from our six most recent guests, we have a special request for listeners. Robbie and I need your help to determine the best ideas and strategies presenting on season two of this podcast.

That's why we're launching the new "Survey to Fix American Healthcare." This time, we want you to image it's the year 2040 and the American healthcare system is now the best in the world. The question we want you to answer is this: How did it happen? How did the U.S. healthcare system go from worst among the 13 most industrialized countries to the best in the world?

In just a moment, we will present the strongest concepts from each guest on season two. You'll be asked to decide which of them is most likely to transform American healthcare in the next 20 years. Please visit RobertPearlMD.com to see a summary of the ideas and cast your vote.

Robbie, to help listeners understand the choices they'll be voting on, can you provide a brief summary of the two most important ideas you heard from each guest?

**Robert:** It would be my pleasure. And listeners, remember, it's 2040 and we're looking back 20 years, asking you to decide which of the game-changing concepts from season two led to the radical improvements in healthcare that made it once again the best in the world.

Let's begin with our first guest from season two, Dr. Devi Shetty, the heart surgeon and the founder of a dozen heart hospitals in India with clinical outcomes as good as the best as in the United States and at a fraction of the cost. Dr. Shetty was Mother Teresa's personal physician and is now the brains behind "Health City," a new hospital in the Cayman Islands, just a one-hour plane flight from Miami. This sophisticated and modern facility is built large enough to treat tens of thousands of Americans each year in the areas of cardiology, pediatric surgery, orthopedics and oncology.

The first game-changing idea that was inspired by Devi can best be thought of as "Global Disruption." Every industry that's as inefficient as the U.S. healthcare system today ends up getting disrupted. Dr. Shetty offers up the perspective that Americans will decide to seek high quality, more affordable healthcare from beyond the U.S. borders. So, if you believe that global disruption will be the process by which Americans improved the healthcare they received, you can vote for this idea when you compete the Fixing Healthcare survey. If that's not the idea you like the most, here's eleven other ideas for your consideration.

A second powerful concept from Dr. Shetty involves the use of 21st century information technology. On the show, Devi noted that today's clunky, desktop computers are poor vehicles for accessing and updating patient health information. On the other hand, doctors look at their smartphones 200 times a day and find the experiencing far less frustrating. That's why he created a smartphone and tablet-based IT system in his hospitals. He believes these mobile technologies will drive global healthcare change and allow doctors to elevate the quality and convenience of the healthcare they provide.

Our next guest, Chip Heath, is the author of multiple New York Times best-selling books, including Switch. His business-focused insights helped inspire these two possible future solutions for American healthcare:

First, Chip noticed in his research that many business leaders try to implement improvements by focusing on the poorest performers. He recommends, instead, that leaders should look for what he calls "bright spots." These are existing success stories that, once identified, can be implemented and scaled broadly. In

healthcare, some providers already are achieving superior outcomes at lower costs. You may agree with Chip that future change will come to American healthcare once we identify, replicate and scale best practices all across the United States.

In addition, Chip believes change often comes through what he calls, and what his book is called, "The Power of Moments." We've seen this happen in the U.S. many times in the past. Think of the how the Stonewall Riots in New York altered the course of gay rights in the United States or photos of children during the war in Vietnam changed public perception of the ethical validity of the conflict. Imagine a child dying from measles, dying excessive drug costs so that the medication required could not be provided, dying from a preventable medical error. Could that moment galvanize the country and force Congress to take meaningful action on healthcare? Although it is impossible to know exactly what the moment would be, Chip suggested that leaders could leverage a major event or emotional story to inspire the types of change that could once again make American healthcare the best in the world.

Our third guest was Elisabeth Rosenthal, the editor of Kaiser Health News, a former New York Times reporter, and the author of the bestselling book "An American Sickness."

In her work as a journalist, Elisabeth led a nationwide effort to expose the outrageously high cost of medical bills. She is a powerful advocate for transparency in healthcare. This is a key potential game-changer. Imagine the improvements that could happen over the next 20 years if every doctor and hospital were required to publicly disclose their pricing and quality-outcome data.

On the show, Elisabeth also said that every voter needs to be a healthcare voter. History is filled with examples of Americans exercising their rights at the polls and demanding change from elected officials. If you believe the democratic process will lead to sweeping improvements in healthcare, you'll want to vote for this option on the Fixing Healthcare survey.

Our fourth guest in season two was Zeev Neuwirth, a primary care physician and author of the recently published book "Reframing Healthcare: A Roadmap For Creating Disruptive Change."

Based on his research, Zeev believes American healthcare providers should adopt what he calls "a marketing mindset." Applying his concept to the future, we can imagine that implementing this approach led to putting patients first and delivering a more consumer-centric and customized version of American healthcare. From Zeev's perspective, patients are already moving in this direction through expanded use of retail clinics and telemedicine.

The next game-changing idea inspired by Zeev deals with the physician burnout crisis. Today, primary care physicians, in particular, feel underpaid, understaffed and report high levels of dissatisfaction. Possibly the solution to many of today's healthcare woes will be that physicians rally together, come together, and demand change on behalf of themselves and their patients.

Our fifth guest from season two was Lindsey Fitzharris, a medical historian with an Oxford PhD. She wrote a New York Times bestseller on the life of Joseph Lister, the Victorian-era physician who discovered antisepsis, revolutionized surgical practice and became one of the heroes of modern medicine.

Listening to Dr. Fitzharris, I was surprised how healthcare remains eerily similar to the past, despite the huge scientific advances of the 20th century. Based on what Lindsey explained about the lives and the impact of individuals like Lister, Semmelweis and Pasteur, do you the listener believe that the American healthcare system will be saved by a handful of pioneers? These will be courageous visionaries who will transform care delivery by the year 2040 through their personal dedication and hardwork.

A second possible choice based on Lindsey's research is that radical transformation will happen not from within the traditional walls of medicine, but through broader societal improvements. We know that much of the extended life-expectancy that has occurred over the past century has come not from advances in medicine but because of cleaner air and water, better nutrition, and advances in public safety. At present, the so-called "social determinants of health," including socio-economics, race and other social factors, have a three-times greater impact on health and life expectancy than medical care, itself. If you the listener thinks that the biggest improvements will come through addressing these types of problems, you should vote for this idea.

Our final guest in season two was Dr. Kevin Pho, a practicing physician and host of the digital platform, KevinMD. Kevin understands that social and digital media can move mountains. He believes these forces can radically improve healthcare in the future.

For example, Kevin notes that today's patients are researching their symptoms and diseases on the internet, whether doctors like it or not. Unfortunately, he points out that much of the information they find is misleading or totally false. Today, there are no prohibitions or regulations to limit or remove dangerous medical information online. But, if there were, Kevin believes patients could find more reliable and trustworthy information and avoid bogus cancer treatments and harmful anti-vaccine messages. In this way, health would improve as people availed themselves of the best medical care possible.

The 12th and final idea for how the American healthcare system will improve was inspired by our conversation with Kevin Pho. Looking back 20 years from now, imagine that Americans used social media to ignite a healthcare revolution. It happened in Egypt during the so-called "Arab Spring," and, more recently, social media became the battleground for the #MeToo movement. The voice of single person may not be able to alter the future of medicine, but many voices banding together on social media could be loud enough to inspire change.

**Jeremy:** There you have it: 12 of the best ideas from season two of Fixing Healthcare. Now it's up to you, the listeners, to vote on which of these concepts will be the ones most likely improve healthcare by the year 2040.

Please go to RobertPearlMD.com and vote for how you think healthcare transformation will happen over the next 20 years. While you're voting on the best ideas from our guests, please add your own ideas for fixing healthcare. We will read the best listener suggestions during Season Three, which begins on Sept 10.

**Robert:** Jeremy, having listened to the thoughts of our season two guests, let me ask you a final question. The New England Journal of Medicine recently published a fascinating look into the mindset of Americans patients. According to public opinion polls, 69% of the public say that reducing healthcare costs should be a

top priority for lawmakers. And, yet, an identical percentage of Americans also believe that the U.S. is spending too little, not too much, on healthcare.

In other words, the majority of us want more medical services, but we want someone else to pay for them. How do you explain the seeming contradiction, and how do you recommend that we address it?

**Jeremy:** You know, Robbie, I think this one is a bit difficult to answer. I think it's natural for people to want the best bang for their buck. I mean, everybody wants something for free or for the best value possible. In the age of Dr. Google, WebMD, and pharmaceutical companies advertising drugs on TV, patients often go to the doctor convinced they know better than their doctor. They might go in convinced they have cancer when its really not or tell their doctor they need a specific drug because of a commercial they saw. I think one of the best ways to address this is better and more preventative primary care. Building an actual relationship with a primary care doc and building that level of trust with a patient while focusing on healthcare versus sick care. I don't think Americans want excessive and expensive care, they want confidence and comfort in the care they are getting. I think a good relationship with a primary care doctor focused on preventative health would go a long way towards driving down costs and give patients a feeling of comfort that they are getting the best care possible.

**Jeremy:** We've greatly enjoyed bringing you this podcast over the past two seasons. Tune in September 10 when we kick of season three of Fixing Healthcare, which will focus on the role of politics and policy in American medicine. The coming season lines up perfectly with what we predict will to be a loud and raucous year of debate by presidential candidates.

In the meantime, please go to RobertPearlMD.com and complete the Survey to Fix American Healthcare. Tell us which of the 12 bold concepts you heard on this show from season two that will help transform American healthcare by the year 2040. While you're there, check out the 10 ideas from season one and see some of the solutions other listeners have suggested.

**Robert:** Please subscribe to Fixing Healthcare on iTunes or other podcast software. If you like the show, please rate it five stars and leave a review. Follow us on LinkedIn and Twitter @FixingHCPodcast. For additional information on a variety of healthcare topics and to vote, please visit my website RobertPearlMD.com.

We hope you enjoyed this podcast and will tell your friends and colleagues about it. Together we can make American healthcare once again the best in the world.

**Jeremy:** Thank you for listening to Fixing Healthcare with Dr. Robert Pearl and Jeremy Corr. Have a great day!